

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27369**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3027**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **General Hospital #2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7-21-41-8-9-41**  
(Specify whether years, months or days) **14 years**

3. (a) PRINT FULL NAME **WILLIAM HARDIMAN**

3. (b) If veteran, **World War** name war. 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Devolia Hardiman** 6. (c) Age of husband or wife if alive **45** years  
7. Birth date of deceased **January 29 1895**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**46 6 11** hr. min.

9. Birthplace **Jamestown Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business

MOTHER FATHER { 12. Name **Deceased** 9  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name **Deceased** 9  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **8/13/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Boonville Mo**

18. (a) Signature of funeral director **Wm. J. Greenleaf**

(b) Address **8118/9 E. 1st St. Kansas City Mo**

19. (a) **8/11/41** (b) **M. J. Brown**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1916 Troost**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **9th**  
year **1941** hour **2** minute **55 p.m.**

21. I hereby certify that I attended the deceased from **7-21-41** to **8-9-41**  
that I last saw him alive on **8-9-41**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute congestive Heart Failure** Duration

Due to **Hypertensive type Heart Disease**

Due to **9310**  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **Same as above & chronic passive congestion of liver, spleen**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **A. C. Turner** (M. D. or other) **8/11/41**  
Address **Gen. Has #2** Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 18 1941

SEP 15 1941

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Geo H Evans*

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**